AMERICAN HEALTH CONSULTANTS

Patient Education Management™

For Nurse Managers, Education Directors, Case Managers, Discharge Planners

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Time management calls for diligence, patience, and creativity

An age-old problem gets revisited

No matter the size of the department, all patient education managers struggle with too many responsibilities and not enough time. When University of Missouri Health Care in Columbia went through a redesign process last year, administrators created a centralized education department that covered community, patient, and staff education.

"One of my biggest struggles is the fact that the department has three distinct areas of responsibility and I must balance multiple priorities. I can't just focus on a top priority because each section has top

EXECUTIVE SUMMARY

In a recent survey, our readers said that time management was one of their top challenges. Many handle multiple job responsibilities and have heavy workloads, yet must meet the patient's needs for education. When there isn't enough time in the day, it is easy to jump from crisis to crisis so that projects aren't finished on time and goals aren't met. Yet it is possible to meet job demands. In our cover story this month, *Patient Education Management* discusses several methods that managers are using to meet this challenge.

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COMING IN FUTURE ISSUES

- Meeting JCAHO guidelines for patient education across the continuum of care
- Recruiting high-caliber volunteers to meet staff shortages
- Providing pharmacy consults for herbal supplements
- Improving compliance of staff reassessment of pain
- Keeping the quality of patient education high in light of budget crunches

priorities," says **Ceresa Ward**, MS, RN, manager of the Center for Education and Development.

Soon after taking the position of patient education coordinator at Great Plains Regional Medical Center in North Platte, NE, **Barb Petersen**, RN, realized she could not do every task that staff throughout the health care facility brought to the education office. "When I took on extra jobs as needed, I was working terrible hours and stressed out beyond belief," she says.

To meet these challenges, both Petersen and Ward developed time management strategies that work for them. They are not alone. Each person who takes on the role of patient education manager must create ways to effectively manage his or her workload.

As a one-person department, **Carol Maller**, RN, MS, CHES, patient education coordinator at the New Mexico Veterans Affairs (VA) Health Care System in Albuquerque, found technology extremely helpful. She embraced as many of the computer applications that were standard for her health care institution as possible. One of the most helpful is a database she uses to manage projects that have many of pieces of information.

For example, medical center staff write most of the patient education materials because it is more cost-effective, the information can be tailored to the institution's patient population, and the material is customized to fit policy. Maller uses the database to manage more than 300 titles of teaching materials, enabling her to keep track of the date each piece was developed so the information can be kept current. She also can organize the materials by subject matter for cataloging purposes.

All clinical areas receive an updated catalogue four times each year or when orders are filled. In addition to listing materials by subject category, the database makes it easy to include a page of discontinued titles and new titles so staff don't have to review the whole catalogue to find these items. "Unless I can automate some of these routine tasks, they eat up all my time and I never have any time for planning or consultant work," says Maller.

Managers must invest time up front learning the computer programs and also building the databases, but it is time well invested. While volunteers could be used in the task of creating databases, they must be carefully selected because it is often more time-consuming to correct their mistakes than enter the data yourself, says Maller.

A handheld, computerized calendar helps Ward keep from overcommitting herself by tracking

appointments and time commitments. The electronic calendar is one of the techniques that she uses to organize her workload. "The electronic calendar allows you to put 'to-do' items on it and track them with reminders so it is almost like a pending file system for workload," says Ward.

It's important to put time on the calendar to work on projects, whether it is electronically tracked or simply the paper version. Otherwise unexpected meetings or a crisis will consume every hour of the day, and it will be impossible to complete or manage projects," says Ward.

Blocking off on the calendar the estimated time it will take to get a task done is important, agrees Petersen. She has a stack of to-do items on one side of her desk that she tries to prioritize and then schedules a time to complete them. "This helps me to get tasks done before deadline and it keeps people from scheduling my day full of events or meetings," she explains.

Through the institution's e-mail system, people can look at her calendar to determine if she has free time that day. If an event or meeting comes up that takes priority over the task, she reschedules the time to work on the project rather than simply canceling it.

A good e-mail program can be invaluable, says Maller. These programs can provide the technology needed to set reminders, notify senders when you are out of the office, provide an alternate contact number, and create folders for special projects, she says.

While Petersen keeps pressing to-do projects on her desktop, she created a multiple file system to make sure there is workspace on her desk. One file contains items that she needs to read but does not have time at the moment to review. She pulls this file out during lunch, while being kept on hold on the telephone, or when she has other downtime, such as while traveling on a business trip.

A second file contains items that Petersen has a meeting in place to discuss. In that way, she doesn't have to waste time looking for the materials she will need at a meeting, ensuring that she can be sure she has done her part to move the project forward. A third file is titled "Waiting for Reply." These are items that she has completed and is awaiting approval on or waiting for another party to complete its portion of the project.

Delegation is an important part of time management, says **Gwen Thoma**, EdD, RN, CNA, director of educational services at Southeast Missouri Hospital in Cape Girardeau. "I quickly realized I get a lot more done through other people than trying to do it all myself," she says. Members of the patient education committee, which meets once a month, share the workload. For example, a committee member might be assigned to develop an education piece on a particular topic.

To keep focused, the committee sets five or six primary goals it wants to accomplish each year, selecting the most pressing needs at the time, says Thoma. For example, the goal was to assess all patient education materials to determine if there were any duplications one year. Each month, committee members looked at handouts in a particular subject category, and when duplicates were uncovered, they were all evaluated to see which ones the institution should keep.

Strategic planning and prioritization is an important element of time management, says Ward. "You really have to decide what is important to accomplish and how you will use your resources to accomplish those priorities," she says.

Due to financial cutbacks, the education department had to take a hard look at community outreach projects to determine where dollars would be most beneficial. A decision was made to focus on the senior market and most of the outreach activities target that population, says Ward.

SOURCES

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Determining where dollars can be best spent helps eliminate some of the projects that eat up time. Some of the projects done in the past may no longer be important, priorities change all the time, she says.

Timesavers not always apparent

The technology used to save staff time often works to a manager's benefit and should not be overlooked. With all patient education materials at Southeast Missouri Hospital on a computer database for easy access by staff, Thoma can quickly see what pamphlets are available in a particular category and if duplications are beginning to crop up. Also, when a test is ordered, the educational sheet pertaining to it automatically prints out so the health care provider can discuss the information with the patient. This can save distribution time because when the teaching sheet automatically prints out, staff don't need constant reminders to make use of it.

New technology to aid staff that is being implemented within the VISN-2 Veterans Affairs Upstate New York Healthcare Network should prove to be a timesaver for management as well, says **Diane Wonch**, PhD, CHES, CHi, patient education director. The on-demand type of closed-circuit TV and personal computer system allows patients or nurses to dial up educational videos via the telephone; it can be used as a patient education survey tool, staff development tool, and customer service recovery tool.

The Healthcare Network is working to have information generated from this technology go directly into the patient's record, such as information from the customer service survey or information on the type of educational videos the patient watched. When completed, time-consuming chart reviews will no longer be needed to retrieve information. "As a manager, I won't have to do a lot of hands-on chart reviews with teams. I can just go into a computer system and call up a video, a program, or a patient population and get my numbers and statistics. That will be quite a timesaver," says Wonch. ■

To manage pain, prescribe a dose of relaxation

Not all treatments require drugs

When determining the best strategy for controlling pain, both pharmacological and nonpharmacological methods are considered at Baptist Health Systems' South Miami Hospital. The nonpharmacological modalities are used in conjunction with medications. "Those nonpharmacological methods that are established and evidence-based can always help in terms of supplementing pharmacological methods," says **Kathryn Worley**, BSN, MSW, manager of counseling services at South Miami Hospital.

EXECUTIVE SUMMARY

As health care institutions continue to work out their pain management strategies, many are acknowledging the benefits of nonpharmacological treatments and incorporating them into their plan. South Miami Hospital is one such facility. In the third article in our series on pain management, we look at how it has incorporated nonpharmacological pain management techniques into its overall pain management strategy and what patient education is needed to implement them.

The nurse at the bedside uses simple interventions. These may be relaxation techniques such as dimming the lights, providing a buffer for any noise that would be disturbing, or guiding the patient in deep breathing. Bedside nurses also use distraction techniques such as music or a movie.

Trained therapists conduct the interventions that require expertise, such as guided imagery or meditation, and are available with a physician's order. Primarily, clinical social workers at the institution are the staff trained in postgraduate meditation and relaxation techniques.

The institution also has four expressive therapies offered on an outpatient basis but also available with a physician's order to acute patients. These include art therapy, music therapy, poetry and journaling therapy, and dance and movement therapy. Therapists who have obtained a credential in that particular modality teach these techniques for pain control. "These expressive therapies are offered in regular groups for the outpatient population, so we really emphasize that the main help from these kinds of therapies comes by doing them on an ongoing, long-term basis," says Worley.

South Miami Hospital has a behavioral medicine department that mainly focuses on pain management interventions for the patients on the units. A second department, which is new, is collaborative medicine. It concentrates on mindfulness stress reduction, which is meditation on a very regular basis and has been shown to be effective with chronic pain, says Worley.

Pair modality with education

With any nonpharmacological pain methods, education is important, whether the patient is required to participate in the intervention or not. The patient needs to understand the process, trust the practitioner, and believe that the therapy will help reduce pain in order for it to work well, says Worley. "We help the patient understand with the data, why it might be effective," she explains.

After evidence is given, if the patient does not believe the therapy will work, it doesn't necessarily mean that the modality should be forgotten. A practitioner might be able to offer other credible references that may persuade the person to give it a chance. However, if patients are resistant, their wishes should never be ignored, says Worley.

It's important to provide education for both staff and patients through credible research from credible organizations. Some nonpharmacological pain management interventions are evidence-based, some have been proven time and again to be ineffective, and some have not been confirmed one way or the other. "There is no solid research yet on magnet therapy and some people find it very successful in their individual use so we would not discourage them," says Worley. **(To learn how patients and family members are educated about the use of herbal remedies while under medical care, see article, right.)**

As with any pain control method whether pharmacological or nonpharmacological, its appropriateness for a patient must be determined by a proper assessment. Ask if the patient has experienced similar pain in the past and, if so, what has worked, advises Worley. Also determine what the patient will consider. The second question to pursue is the type of pain the person is having because some nonpharmacological interventions work better on certain types of pain than others. For example, massage, another modality offered at South Miami Hospital, is very good for back pain, says Worley.

The type of nonpharmacological intervention does depend on the patient's health problem as well as physical limitations. Sometimes, a modality can be altered to fit the patient's need. For example, while people with pulmonary disease often have difficulty laying in a prone position for a massage, they can be positioned in a chair for one and it seems to ease their anxiety and pain.

"Every situation is very individual and requires that assessment to evaluate what might be best for them," says Worley. **(To learn how to use nonpharmacological pain management techniques with children, see pediatric insert in this issue.)**

Currently, South Miami Hospital is considering the implementation of a pre-op class in guided imagery and meditation for scheduled surgery patients. It would be a one-and-a-half- to two-hour group class for people considering surgery. There would be some basic training in meditation and relaxation techniques that the patient could incorporate after surgery.

While a patient can be guided in meditation and relaxation exercises without any teaching, it is better for patients to learn the skills so that they might make use of them on their own. "It is empowering," says Worley. ■

SOURCES

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Education sets patients straight on supplements

It takes two departments

Many patients place herbal remedies and over-the-counter nutritional supplements in the nonpharmacological category of complementary therapies, yet they are pharmacological, says **Kathryn Worley**, BSN, MSW, manager of counseling services at South Miami Hospital. Therefore, both the nutritional department and pharmacy department work together on possible drug and nutritional supplement or herbal therapy interactions to keep staff updated so that they can provide

timely education to patients and family members.

It's important that patients know to tell their health care providers about any herbal remedies or supplements that they take. It's also important that family members are instructed not to bring hospitalized patients such remedies without asking the staff, adds Worley.

Drug/herbal interactions also are part of the pain facts patients are given upon discharge. "It is an initiative that we have just started," says Worley. ■

Reader Questions

Audits become best documentation motivator

Effective form just the first step

Question: "What have you done to improve documentation of patient education? What have been your most successful methods for improvement? How do you monitor compliance numbers and what do you do if those numbers begin to slip?"

Answer: It is not enough to create a form for documenting patient and family education, documentation must remain at the forefront of staff education for compliance to be consistent. "I have tried many approaches to improving documentation. What I have settled on is a chart audit approach conducted by a couple RN's," says **Kris Becker**, RN, MHA, director of orthopedic services at Sacred Heart Medical Center in Spokane, WA.

As these two nurses track monthly compliance with documentation and education standards on a chart audit tool, they simultaneously fill out a feedback sheet for staff members who provided the documentation. The feedback tool follows the chart audit and has preprinted information and reminders. **(See example of information included in feedback tool on p. 139.)**

Becker tracks the specific area of deficiency for each individual staff member and uses the data to identify trends. She also uses the data as part of staff's annual performance appraisal. "It is not an option to not follow the documentation policy," she explains. When a staff member receives a feedback sheet, he or she is required to sign the form and return it to her within two weeks.

"I occasionally have staff do unit chart audits. However, I do not use these audits for data collection, only for education purposes," says Becker.

WellSpan Health in York, PA, also uses chart audits to track documentation and completes audits on a semiannual basis. Auditors verify if a documentation form was placed in the chart, if barriers were addressed, if all appropriate disciplines used the form, and what was documented, explains **Nancy Miller**, RN, MBA, patient and family education coordinator at WellSpan. Last winter, audits revealed that 85% of the charts had patient education forms with some documentation, but only 54% had barriers addressed, and nursing was the only consistent group to document.

To bring the numbers up, several areas have the nurses bring the teaching record to multidisciplinary rounds along with the patient's plan of care to be sure appropriate education is being provided and documented. When a specific nursing unit identifies that there is not consistent documentation, they develop a plan to address the problem.

For example, the maternity area decided that each nurse would have three charts to review for one week, then rotate to three others on an ongoing basis to track the documentation compliance of a colleague. The nurse was responsible for telling the colleague reviewed if there was a problem and also report it to the manager. "The nurses felt this would also help them to identify what they were forgetting. After two months, they found that documentation had improved significantly," says Miller.

The multidisciplinary committee for patient and family education also is proving to be helpful with documentation adherence. Group members stress the importance of documentation to all who provide patient teaching, says Miller. Each discipline has annual education days where they review patient education and its documentation. In addition, every discipline is encouraged to remind their colleagues to document when they see them providing education. Patient education was added to the health care institution's annual competency education as well.

"With our focus on a known location and reemphasis on patient education our numbers have improved," says Miller. The last audit revealed that 95% of the charts had education forms with documentation, 87% had the barriers to education addressed, and 92% had all appropriate disciplines documenting.

A commitment to remain in a constant state of

SOURCES

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readiness for a Joint Commission on Accreditation of Healthcare Organizations survey helped boost compliance with documentation of patient education at Shands at the University of Florida in Gainesville. To remain ready, a Joint Commission clinical group was formed that is chaired by the director of nursing and director of operations and has representatives from all the clinical disciplines.

Members of this committee are given chapter assignments from the Joint Commission Standards and are responsible for ensuring that the health care facility is meeting the standards within those chapters. One group looks at patient education, which includes documentation, explains **Kathy Gamble**, ARNP, MN, CPON, OCN, coordinated care manager of the department of nursing and patient services at Shands and co-chair of the interdisciplinary patient and family education committee.

To help monitor documentation, the medical records department conducts monthly closed chart audits. When the audits first began, the numbers revealed a need for a lot of work. Therefore, a one-time meeting was held to develop an action plan, says Gamble. The group that met included the members of the patient education committee, the Joint Commission clinical group, the closed-chart review group, licensure and accreditation, and nursing documentation.

The patient education committee implemented the plan, which included making the documentation requirements for education records a hospital policy. To make documentation of patient education less time-consuming, the record is referred to as an index to patient education. Disciplines that have detailed education notes on another part of the chart are asked to make a note on the record so they don't have to double-document, so the information can be found easier, says Gamble.

"It has helped for staff to know that documentation is something we are watching. It has improved our compliance," says Gamble. ■

Feedback tool improves staff documentation

Serves as an effective reminder

To provide feedback on documentation compliance, nurses in Orthopedic Services at Sacred Heart Medical Center in Spokane, WA, are given a sheet that shows them the areas in which they need improvement each time charts are audited. The feedback sheet follows the chart audit and has preprinted information and reminders, says **Kris Becker**, RN, MHA, director of Orthopedic Services. Areas covered include completion of the advance directive sheet, patient history, adult interdisciplinary data record, and plan of care with concerns, interventions, and expected outcomes listed.

When patient education assessments are not completed, that point is checked on the feedback sheet. The feedback tool reminds nurses that assessment covers a patient's learning needs, preferences, and barriers to learning, and that all three sections need to be assessed.

"If their documentation did not include response to the pain management intervention, the feedback tool gives them a hint on ways to do that," says Becker. Incomplete documentation of pain management covers several issues that can be checked during a chart audit, such as:

- There should at least be documentation of the patient's pain rating at the beginning of your shift — initial assessment.
- Please chart every time you ask the patient to rate their pain throughout the shift, even if it does not result in an intervention.
- It is important to chart the patient's response to the pain medicine. Even if you don't ask the patient to rate their pain again until it is time for more pain meds, you can ask them, "Did the pain pills help your pain? What rating would you give that?" Then chart that in the response area. ■

Yoga good for stress and other ailments

Moving from health clubs to hospitals

Yoga has been popular at health clubs for a while, used as a method for making tight muscles more supple. Yet those who practice it say it is beneficial for the entire body including the skeletal, nervous, glandular, and circulatory systems. It helps improve specific health conditions as chronic low back pain and heart disease.

"A lot of the movements that are generally prescribed by the physical therapist are similar to some of the yoga exercises. The only difference is that in yoga, you do the exercises with a very precise breathing technique and meditation to quiet the mind," says **Patricia Rockwood**, a yoga instructor and spokeswoman for the American Yoga Association in Sarasota, FL. People also practice yoga to manage stress, anxiety, and anger because it is very relaxing.

Most adults can do some small movement no matter their physical condition or at least the breathing and meditation, says Rockwood. The association has an Easy Does It Yoga program with adapted yoga techniques for people with severe physical limitations. "There are movements people can do in a chair or even in bed," she says. **(To learn how yoga is incorporated into The Place of Wellness at M.D. Anderson Cancer Center in Houston, see article on p. 141.)**

Truly an individual exercise form

People who decide to try yoga should know that it's important to do the exercises at their own pace and never model their movement after the teacher or another individual. The yoga exercises must be done with the limitations of each person's body in mind. Choose a teacher who has a small enough class that he or she can work with each student, advises Rockwood.

A class should have all three components of yoga, which include the exercise movements, breathing, and meditation. "The meditation is almost like a wrap-up. You have done some exercises and breathing, your mind is starting to get still, and then when you let everything go for a few minutes, it makes it all work better," says Rockwood. The term yoga means to yoke, or join the mind and body.

SOURCE

For more information about yoga and its benefits, contact:

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Before signing up for a class, students should make sure the teacher has practiced yoga for a couple years and studies under a teacher as well. "You never get so far advanced that you lose your need to have a teacher," says Rockwood. A teacher should practice every day, because he or she can't be a good teacher if it is only a hobby, she says. While many teachers practice Hatha Yoga, there are over a hundred different schools of yoga, according to the American Yoga Association. These include Raja Yoga, Jnana Yoga, Bhakti Yoga, and Karma Yoga.

Every teacher is trained in the tradition of the particular organization he or she belongs to, and each has its own standards and requirements for certification. Some organizations certify teachers after a two-week training course, while others require several months or more of training. There is no national standard for yoga teachers; therefore, it is important to learn the criteria used for certification by the organization the teacher selected to train under, says Rockwood. **(To learn the American Yoga Association's criteria for selecting a yoga teacher, log onto their web site at www.americanyogaassociation.org.)**

Books and videos are a great supplement to classes because they can be used as a reminder of the various postures taught by the teacher. If a person is not practicing with a teacher, most of the books and videos are designed for self-study.

Items needed to practice yoga can be found right in people's own homes. The movements can be done barefoot and wearing any type of exercise clothing. "We suggest that people put on a pair of socks when they meditate because their body temperature drops during that time and they won't want to become chilled," says Rockwood.

Many think that they need a special mat for the exercises, but a beach towel or old blanket works well. However, it should be dedicated to yoga practice because in that way, it will begin to help the person get in the mood, says Rockwood. A foam mat is necessary if practicing on a wood or concrete floor and should be one of the sticky

mats found at sports stores so that it won't slip. If doing seated breathing exercises, a couple throw pillows help take the pressure off the lower back, she says. Breathing techniques also can be done sitting on the edge of a chair.

One of the most important things people should know before beginning yoga is that it must become part of their daily routine if they want it to be effective. It works best with at least 20 minutes of practice each day. "The ideal is to make it a habit just like brushing your teeth every day," says Rockwood. ■

Cancer patients find relief in yoga

For best results, tailor postures to each participant

The Place of Wellness at M.D. Anderson Cancer Center in Houston has offered classes in Hatha style yoga since it opened three years ago, beginning with one class per week and adding more as needed. Now three yoga sessions are offered weekly. As with the other classes at this health center, the purpose is for relaxation and symptom management, such as pain and fatigue.

"One person may use the class to incorporate active meditation into their symptom management. Another may be having some frozen shoulder issues after breast surgery and want to regain some sense of motion," says **Laura Baynham-Fletcher**, MA, LPC, manager of the Place of Wellness. Yoga energizes and refreshes patients suffering from cancer fatigue as a result of chemotherapy, radiation, and multiple surgeries.

Due to the health problems of many who come to the Place of Wellness, all participants are asked to complete a screening tool whether they are a patient, caregiver, or family member. People are asked if they have balance or musculoskeletal issues or a history of fractures or fainting. The screening tool isn't used to keep patients from participating, but to tailor the activity to their needs, says Baynham-Fletcher.

For example, patients having problems with balance might be given a chair to steady themselves or even stay seated during the exercises depending on the frequency or severity of the balance problems. The instructor would then work with them on modification for seated postures. "We don't want to turn people away because they have these kinds of issues. That is why we are here," says Baynham-Fletcher.

SOURCES

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The unique setting also makes screening of instructors important as well. Before yoga instructors are hired at the Place of Wellness, they must submit a program proposal that includes their perception of the objectives for the class and their credentials. They are also asked to provide information on what classes they currently teach and the populations those classes serve. Staff from M.D. Anderson then visit the instructor's class or the instructor provides a demonstration at the health care facility.

"What is unique about our credentialing process is that we mentor the instructor with someone from M.D. Anderson who is most closely related to their expertise," says Baynham-Fletcher. Therefore, the yoga instructors work with the director of rehabilitative services to go over the postures that would be most likely used in the class and adapting them to meet the patient population of M.D. Anderson. ■

Teach public to control colorectal cancer

Promote screenings to decrease deaths

The message promoters of National Colorectal Cancer Awareness Month want to get across to the public in March is that this form of cancer is preventable. "Our mission is to explain to people that if they get screened, they can prevent cancer through the removal of polyps or detect it early enough that it is 90% curable. People can take control of this cancer as opposed to just waiting for it to happen," says **Sonja Weisel-Jones**, assistant director of external affairs at the Cancer Research Foundation of America in Alexandria, VA.

Although widespread screening for colorectal

cancer is available and effective, it lags behind screenings for other types of cancer such as mammography, Pap smears, and prostate exams. Physicians detect only 37% of colorectal cancers at an early stage. The foundation estimates that 30,000 lives could be saved annually with colorectal cancer screenings.

People need to learn about the different types of screenings so that they can talk to their physician about which one is right for them, says Weisel-Jones. Screening methods include fecal occult blood testing, flexible sigmoidoscopy, double contrast barium enema (barium X-ray), and colonoscopy. These screening methods can detect precancerous polyps, which are grapelike growths on the lining of the colon, as well as detect the cancer if it has started to develop.

Everyone over the age of 50 should be screened annually, and those people at a higher risk for colorectal cancer should be screened earlier. Those at high risk include people who have a personal or family history of inflammatory bowel disease, colorectal cancer or polyps, and ovarian, endometrial, or breast cancer.

Colorectal cancer is not gender-specific; both men and women are diagnosed with the disease with equal frequency. It is second only to lung cancer in the number of deaths it causes in the United States. The foundation estimates that this year, 56,700 people will die from colorectal cancer and about 135,400 new cases will be diagnosed.

Dispel myths with education

What prevents people from being screened? Colorectal cancer testing is very complicated and there are a lot of mixed messages about it, says Weisel-Jones. People find some of the screenings such as the colonoscopy to be very invasive and they are afraid that it will hurt. Others think that a screening is to detect cancer and they would rather not know, she says.

However, the annual screening would probably be the fecal occult blood test, a simple chemical test that can detect hidden blood in the stool. It can be taken in a person's home and sent to a laboratory for results. A colonoscopy would be ordered if something was detected, explains Weisel-Jones.

A lack of understanding about the benefits of screening also keeps the numbers low. In about 75% of all new cases of colorectal cancer, the only known risk factor is age, with the person developing the disease at age 50 or older, according to the Cancer Research Foundation of America. Because colorectal cancer develops from polyps, removing them may prevent the cancer from developing.

SOURCE

For more information about National Colorectal Cancer Awareness Month, contact:

- **Sonja Weisel-Jones**, Assistant Director of External Affairs, Cancer Research Foundation of America, 1600 Duke St., Suite 110, Alexandria, VA 22314. Telephone: (703) 519-2104. Fax: (703) 836-4413. E-mail: sweisel@crfa.org. Web site: www.preventcancer.org/colorectal.

In addition, early detection can save a person's life. If the cancer is confined to the colon or rectum when it is diagnosed, patients have a 91% chance of surviving. Yet only 37% of colorectal cancer cases are diagnosed at an early stage. "Colorectal cancer is not a cancer that you always catch right away without screening because there are no signs and symptoms. As with any cancer, when you do have symptoms it is generally when the cancer is further on and less treatable," says Weisel-Jones.

Symptoms for colorectal cancer according to the Cancer Research Foundation of America include:

- bright red or orange blood in or on the stool;
- change in bowel habits, such as diarrhea or constipation;
- stools that are narrower than usual;
- general stomach discomfort such as bloating, fullness, or cramps;
- feeling that the bowel does not empty completely;
- frequent gas pains;
- weight loss for no apparent reason;
- rectal bleeding;
- constant tiredness.

During National Colorectal Cancer Awareness Month health care facilities can have a fecal occult blood test drive where free screening kits are passed out to participants who will return to obtain lab test results. It's helpful to have a health care provider present to answer questions and provide education, says Weisel-Jones.

The target population for the screening would be up to the community base, she says. For example, if there was a large African-American population in the area, it might be a good target because they are at higher risk. The death rates are higher for African-Americans diagnosed with

colorectal cancer than other ethnic groups.

There are many free educational materials available from the Cancer Research Foundation of America that are designed to be reproduced and can be ordered on-line or by telephone. There is a brochure and a sheet that explains the myths of colorectal cancer that is available in English and Spanish. There's also a medical history chart people can fill out and give to their health care provider, a sheet with steps for helping people learn their risk for colorectal cancer, and a list of questions patients can ask their health care provider.

"There needs to be shared decision making between the physicians and the patients," says Weisel-Jones. ■

Education must target emergency preparedness

With the terrorist attacks on the World Trade Center in New York City, many people were displaced from their homes. Now there is the fear of contracting anthrax, although people are being exposed one by one rather than on a mass scale, which might require evacuation. With these recent events, it is clear that people need to be prepared for whatever emergency might occur.

"If people are ordered to evacuate, they need to be able to move out of their houses quickly. In order to do that, those on medications should have them located in one place," says **Carol Maller**, RN, MS, CHES, patient education coordinator at New Mexico Veteran Affairs (VA) Health Care System in Albuquerque.

If medications are scattered throughout the house, they will not only have difficulty finding them quickly, they might leave some behind, she explains. It's also important that they keep adequate refills of their medications on hand and don't let their prescriptions run out.

Maller has begun working with the disaster coordinator at the Albuquerque VA to create an information list for patients that provides advice on how to put together a simple disaster supply kit that they could take if they had to quickly evacuate. These might include a few bottles of water, critical medication, and a flashlight. The American Red Cross web site (www.redcross.org) offers information on this topic, but the Albuquerque VA wants to individualize the list for its patients, says Maller.

While the effort still is in the infancy stages, the list would probably be widely distributed rather than targeting high-risk groups. "People need to start talking to their provider and thinking about what they need to do to be prepared and which of their medications are the critical ones," says Maller.

It's important to work with the person in charge of disaster planning at your health care facility when creating information to distribute to the public, says Maller. "We want to make sure that we are consistent in the information we give out to people," she says. ■

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Editorial Questions

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CE/CME Questions

21. Good time-management techniques used by patient education managers include:
    A. computer software applications.
    B. delegation of tasks.
    C. prioritizing workload.
    D. all of the above

22. Which of the following techniques are used to ensure that patient education is being documented?
    A. Chart audits
    B. Shadowing employees
    C. Docking pay
    D. Posting personal documentation errors

23. Screening for colorectal cancer could help prevent the disease by detecting polyps in their precancerous form.
    A. True
    B. False

24. To effectively use nonpharmacological pain management techniques with children, it is important to:
    A. tailor technique to age.
    B. when possible, work with child.
    C. select technique and stick to it.
    D. A and B

Have ideas for consumer/ staff needs for bioterrorism preparedness?

Is your institution preparing for national emergencies in light of the recent anthrax scare by creating plans for consumer and staff education? If so, we would like to know what educational programs and/or materials you are putting into place. We would welcome guest columns written on this topic, or information that we might include in an article. Contact Susan Cort Johnson, Editor, *Patient Education Management*, at (530) 256-2749 or via e-mail: suscortjohn@onemain.com. ■

CE objectives

After reading *Patient Education Management*, health professionals will be able to:

- identify management, clinical, educational, and financial issues relevant to patient education;
- explain how those issues impact health care educators and patients;
- describe practical ways to solve problems that care providers commonly encounter in their daily activities;
- develop or adapt patient education programs based on existing programs from other facilities. ■

Focus on Pediatrics
PATIENT EDUCATION MANAGEMENT'S MONTHLY SUPPLEMENT

Temperament, age help shape pain control

Tailor nonpharmacological management techniques

When using nonpharmacological pain management techniques with children, consider the age of the child and his or her temperament, advises **Lori Schweighardt**, CCLS, a child life specialist at Phoenix Children's Hospital. "The techniques need to be individualized; so it's important to work with the patient and family to find out what is going to work best in a particular situation," she explains.

Talk to the parents to find out if the child has had any painful experiences, or has even been sick in the past and what worked then. He or she may be the type of child who wants to be left alone with the lights off when in pain. On the other hand, the child may want to listen to music and have a foot massage from Mom, which is more of a distraction technique. "If the child is old enough, you can ask him or her questions about pain management," says Schweighardt.

It is important to determine what type of personality a child has when determining the best way to help him or her cope with pain, agrees **Chris Brown**, MS, CCLS, director of child life and education at The Children's Hospital of Philadelphia. "We can start to assess children as young as toddlers to determine what type of personality a child has, whether really curious or fairly distractible," she says. If a child is curious, they are better off during a procedure if allowed to look at what is happening and play with the stethoscope or a cotton swab.

Whenever possible, it is good to rehearse the nonpharmacological pain management or coping technique ahead of time. It's also important to involve children in the planning stages so that they buy into the technique and actually do it during a painful procedure or if in pain, says Schweighardt.

Talk about what will happen during the procedure so the child has an appropriate understanding, then talk about ways to make the procedure a little easier. "I ask children what they would like to do while we are doing the IV, and some will know and some won't. If not, I offer some suggestions, such as reading a book or blowing bubbles, to generate some ideas."

Schweighardt encourages the children to choose several options vs. one technique. For example, they might want to squeeze Mom's hand or bring along a favorite stuffed animal. "We find that kids in hospitals feel like they don't have control, so we give them choices whenever we can so they get some of their control back," she says.

No matter which pain control technique children want to use, it must be age-appropriate. For example, if deep breathing is used to help a child relax and ease pain, it would be tailored to the age of the child. A 1-year-old would not understand a verbal instruction to take a deep breath, but would copy a parent or child life specialist. "They can do a lot of modeling for that child about blowing out so he or she can imitate them," says Schweighardt. Blowing bubbles is a nice way to get children to take nice deep breaths. **(For examples of age appropriate nonpharmacological pain techniques, see article on p. 2.)**

Even with practice, the techniques may not always work during the stress of the actual procedure, so it's important to be prepared to try something else. For example, if deep breathing is not working, tell a story, says Schweighardt. It's also important to make sure that the parents are involved in the training so that they can help with the child. "Parents can be a calming effect,

SOURCES

For more information about nonpharmacological pain-control methods for children, contact:

- **Chris Brown**, MS, CCLS, Director, Child Life and Education, The Children's Hospital of Philadelphia, 34th Street and Civic Center Boulevard., Philadelphia, PA 19104. Telephone: (215) 590-2001. E-mail: brownc@email.chop.edu.
- **Lori Schweighardt**, CCLS, Child Life Specialist, Phoenix Children's Hospital, 1111 E. McDowell Road, T4D, Phoenix, AZ 85006. Telephone: (602) 239-4137. E-mail: lschweig@phxchildrens.com.

plus we want them to be part of a child's care," she says. In addition, they will be able to use the techniques in future medical situations, such as when their child is being immunized.

However, a child cannot always be prepared for a painful incident. In an emergency situation, it often helps to just give a child information on what is happening in a calm voice. "There is always a place for nonpharmacological pain techniques. It can be in the form of a calming voice telling the child what is happening. Lack of information is a big part of fear which can really add to the pain," says Schweighardt. ■

From infancy to teens, pain control is possible

Select method that matches developmental stage

"In conjunction with pharmacological pain management, nonpharmacological techniques can be very effective with children of all ages, even in infancy," says **Chris Brown**, MS, CCLS, director of child life and education at The Children's Hospital of Philadelphia. However, the technique must be appropriate for the child's age. Following are a few suggestions:

• **Infancy.**

Relaxation techniques to ease pain that are appropriate for a baby include soft lighting and music, such as a lullaby. Swaddling an infant is comforting as well. A pain control technique will only be comforting to a child if he or she is used to them. "Playing music for a child who is not used to music will not be relaxing, but if Mom sings to the baby on a regular basis, that could be a good technique for relaxation," says Brown. It's important to find out what is normal for the child. That's why a favorite blanket, a teddy bear, or the presence of the parent is comforting as well, she says.

• **Toddlers.**

For this age group, distraction is one of the best techniques for easing pain or helping them through a painful procedure. Relaxation techniques used with infants can be effective such as music, rocking, or holding a favorite blanket. "At that age, they can be verbally assured as well," says Brown.

At the toddler stage, children can be told a little bit about the procedure, and it eases the stress if they are not surprised, she says.

• **Preschool children.**

Preschool-age children can begin using more advanced relaxation techniques. For example, they can follow verbal instructions for deep breathing and take a breath in and blow it out as they are told, says Brown. Distraction techniques such as pop-up books, puppets, or bubbles still work well with this age group.

"At about age 5 or 6 in addition to all of these techniques, we can start adding some positive self-talk," says Brown. This technique actively turns the child's thoughts from the negative aspects of the procedure to what they can do to get through it. For example, Brown might read the story *The Little Engine That Could,* and then encourage the child to repeat the words "I think I can, I think I can!"

• **School-age children.**

Children ages 7-12 want information about the procedure even if they don't have the personality type who wants to watch. "They don't want surprises or to be told that something doesn't hurt if it does," says Brown. They also want some control, so it is a good time to get them involved in pain management decisions. This is the age when children can get more involved in the imagery kind of techniques: Imagining that they are at the beach, for instance. They have the cognitive ability to think about something else and consciously change their breathing, says Brown. They can also do progressive muscle relaxation responding to verbal prompts.

• **Adolescents.**

The techniques that are appropriate for school-age children also work with adolescents, however, they need to be presented in a more mature fashion. For example, teens might not choose Disney World as their favorite place when using imagery to ease pain.

Music assisted relaxation works well if teens choose their own style of music. "Teen-agers aren't going to want to listen to Mozart in the treatment room. They would rather put on their favorite music, and while it may not be technically relaxing in terms of slowing down the heart rate, it might be mind altering in some way and help manage pain," says Brown.

It's important to remember that most nonpharmacological pain management strategies are learned techniques, and their success depends a lot on the child's temperament. "If a technique doesn't work the first time, that doesn't mean it won't ever work," says Brown. ■

AMERICAN HEALTH CONSULTANTS

2001 SALARY SURVEY RESULTS

Patient Education Management™

For Nurse Managers, Education Directors, Case Managers, Discharge Planners

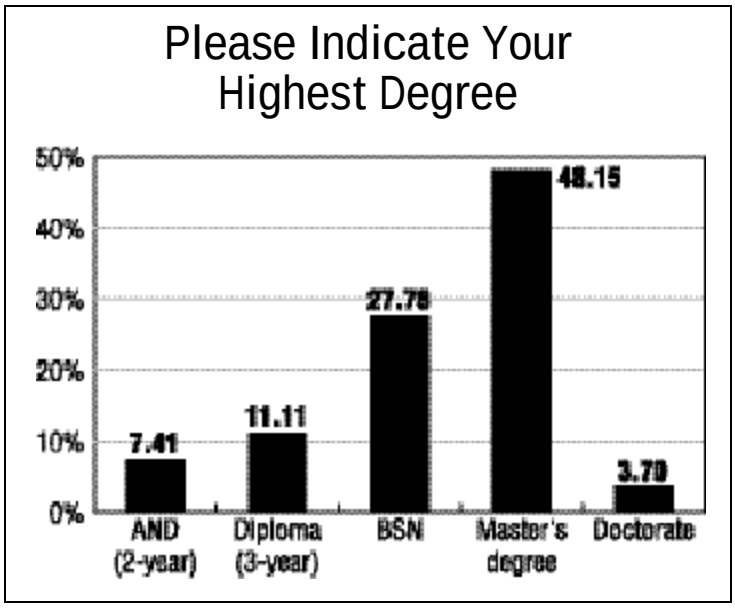
Advanced degree more common in job requirements

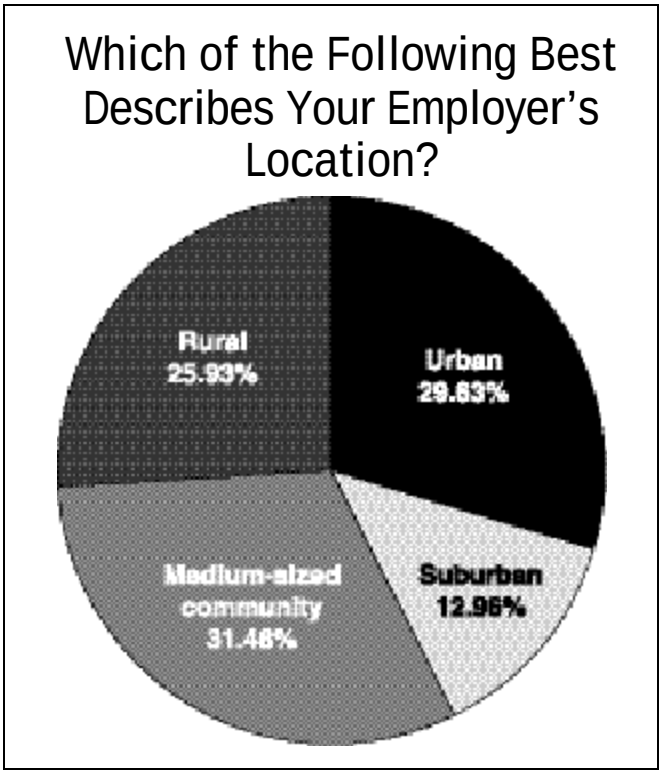
Patient education managers can expect multiple job duties

Many factors are shaping the job responsibilities of patient education managers. Diminishing resources within the health care industry create pressure for more efficiency and patient education managers must do more with less. Yet dwindling funds are never an excuse for mediocrity.

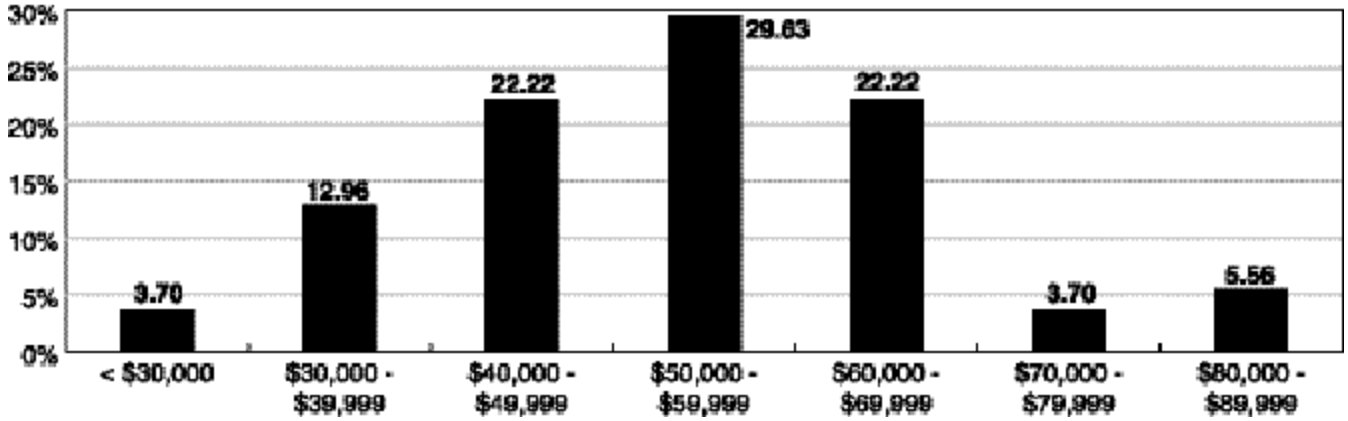
Quality improvement is a major emphasis of patient education as well as compliance with the standards set by the Joint Commission on Accreditation of Healthcare Organizations based in Oakbrook Terrace, IL. Although most patient education managers still are trying to implement the pain standards established by the Joint Commission, it's new emphasis is on patient safety, says **Annette Mercurio**, MPH, CHES, director of patient, family and community education at City of Hope National Medical Center in Duarte, CA.

Due to lack of reimbursement for services, most





What is Your Annual Gross Income?

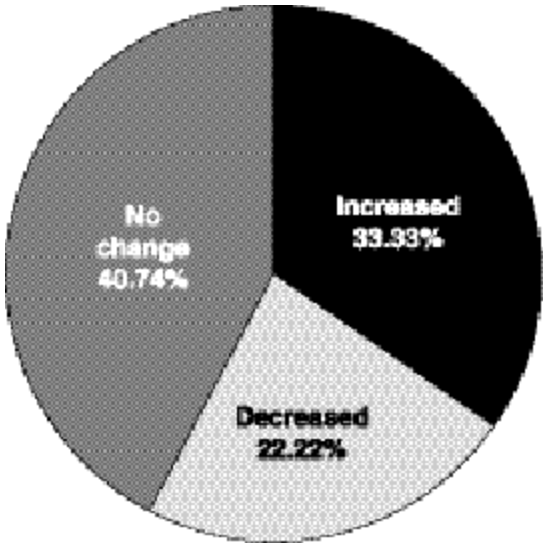


health care organizations are under budget constraints; therefore, job descriptions usually encompass a variety of responsibilities. When there are multiple tasks to be done, prioritization is of utmost importance, says **Dorothy Ruzicki**, PhD, RN, director of the department of educational services at Sacred Heart Medical Center in Spokane, WA.

With too much to do in too little time, it's not surprising that a number of readers indicated they worked more 40 hours a week and often as much as 50 hours. The number of hours worked would probably depend on the size of the facility and range of responsibilities, says Ruzicki. If a patient education manager is responsible for a multihospital system's patient education across the continuum of care and oversees patient education at a big facility, that could add up to a lot of overtime, she says.

There were readers who indicated that they worked less than 40 hours a week; however; there could be several reasons for this, says **Mary Szczepanik**, MS, BSN, RN, manager of cancer education, support, and outreach at Grant/Riverside Methodist Hospital in Columbus, OH. The health care facility might only have a part-time position for patient education coordinator or it is possible that the person holds more than one title, splitting his or her time between two jobs. A third scenario is that a job-sharing arrangement is in place and two people split the duties and hours of the position of patient education manager. "If a peron is in a managerial position, there is no such thing as a 40-hour work week," says Szczepanik.

In the Past 12 Months, How Has the Number of Employees in Your Company Changed?

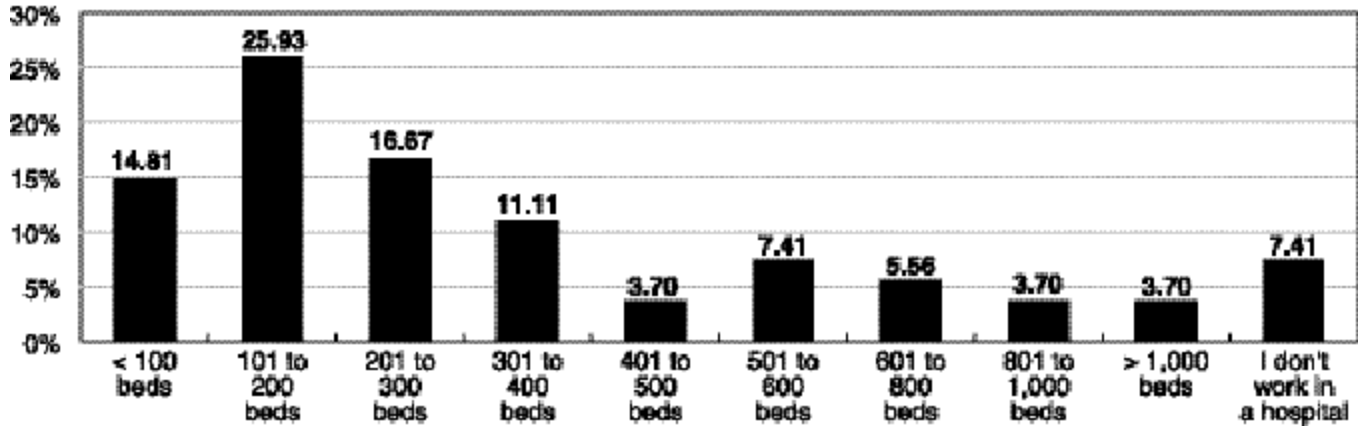


Higher degrees the norm

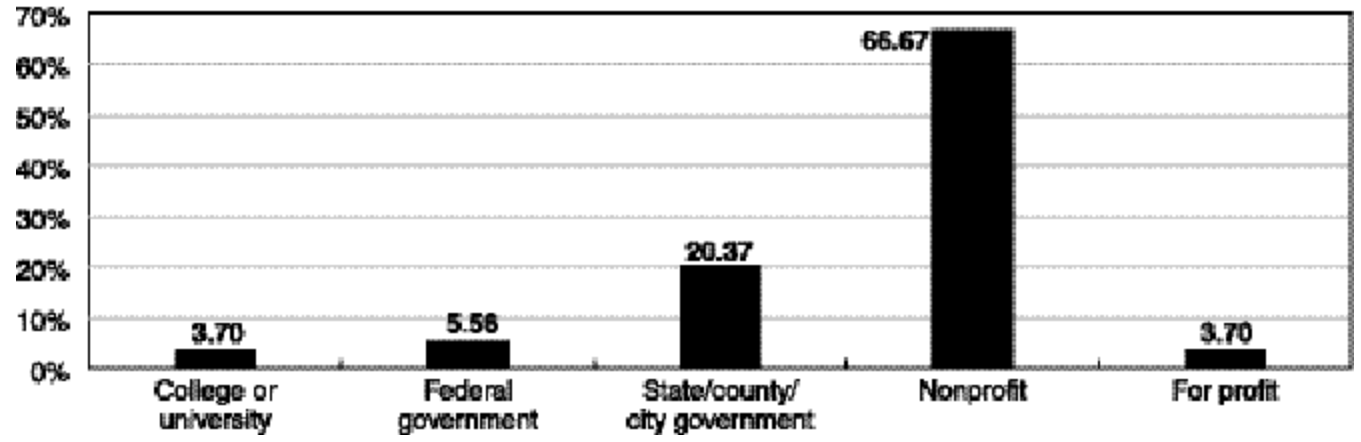
Although a majority of our readers who answered the salary survey indicated that their job title was patient education coordinator rather than manager or director, many had a master's degree. At Northwestern Memorial Hospital in Chicago, an advanced degree is desirable when applying for a higher-level position, whether a manager or not, says **Magdalyn Patyk**, MS, RN,

(Continued on page 4)

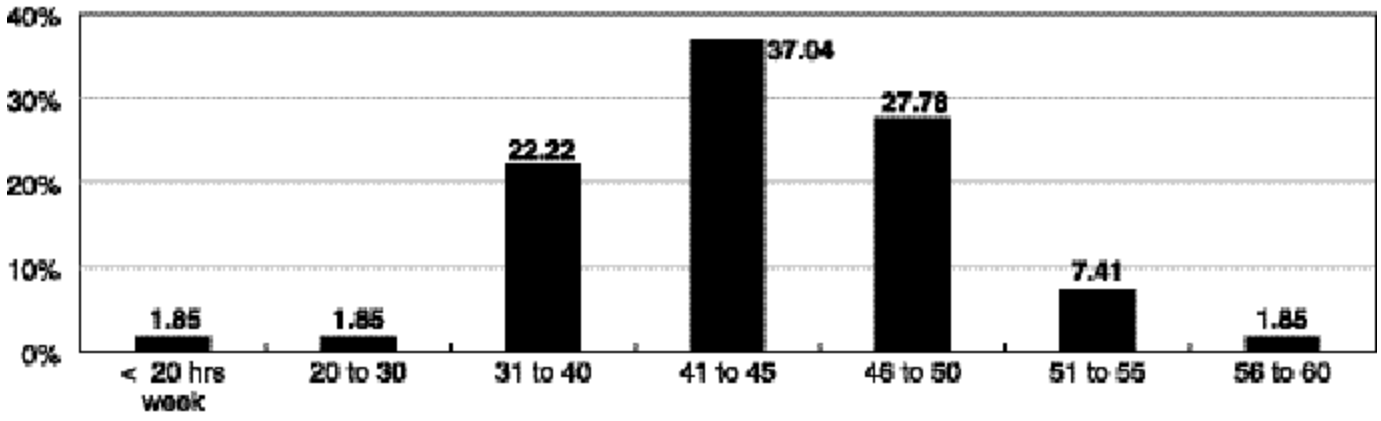
If You Work in a Hospital, What Size is Your Facility?



Which Describes the Ownership or Control of Your Employer?



On Average, How Many Hours a Week Do You Actually Work?



patient education consultant. Whether an advanced degree is rewarded with a higher salary is difficult to say. It depends on the organization, she says. More and more entry-level positions for manager require a master's degree, says Mercurio. "More than shaping salary, it shapes whether or not a person will be qualified to apply for the job."

Pay scales dictate titles

Title is not always a good indicator of salary either. It depends on the organization, but titles are usually tied to a certain pay scale, says Patyk. "I think it is the organizational structure that actually determines the title in addition to the responsibilities given," she explains.

Title probably doesn't impact salary all that much, however the requirements of the job would, agrees Szczepanik. "Many organizations look at what the market is paying for a position when they calculate salaries," she says. Therefore, there would be regional differences in salary to compensate for cost-of-living differences.

However, working at a small hospital in a rural location might not have a negative influence on salary as one might expect. Many rural hospitals have merged with hospital systems in larger cities, thus pay scales for positions within the same system would be comparable, says Szczepanik.

Size not a factor

The size of the hospital would not necessarily dictate title or even whether or not there is a patient education manager. It depends on the model of service delivery, says Ruzicki. For example, at Sacred Heart Medical Center with over 600 beds, patient education coordination is handled within each service line such as surgical, cardiac, pediatrics, or women's services. The department of educational services oversees staff development and is responsible for developing supportive materials for patient education.

Salary may not be impacted by the size of an institution either, says Patyk. It depends on how much an institution values it, she says. Yet many factors have brought patient education to the forefront and increased its importance. This includes its role in patient satisfaction, the importance the Joint Commission has placed upon patient education, and health care consumerism, says Patyk. ■

SOURCES

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BIOTERRORISM WATCH
Preparing for and responding to biological, chemical and natural disasters

Clinicians must be voice of reason, reassurance now that bioterrorism battle has been joined

The threat is real, but we are far from defenseless

A new era of bioterrorism has begun with the intentional anthrax scares that have left several people dead and many more exposed as this issue went to press.

But amid the shrill coverage of the widening anthrax investigations, the scramble for gas masks and the expected hoarding of Cipro, there must be a voice of calm and reason. That voice must be your own.

Infection control professionals, hospital epidemiologists, and other key clinicians involved in health care bioterrorism readiness and response must set the tone for a panicky public and an uneasy health care work force, emphasizes veteran epidemiologist **William Schaffner**, MD, chairman of preventive medicine at Vanderbilt University School of Medicine in Nashville.

"We have to re-instill a sense of confidence for people who work in the health care system," he says. "Start with the doctors. They are the ones who are going to be more panicked than the nurses."

Restoring calm to health care community

The current situation is reminiscent of the early stages of the HIV epidemic, when there was much anxiety about the communicability of the disease and whether even casual contact would spell a death sentence for health care workers.

In that chilling time of alarmist reactions and burning mattresses, Schaffner recalls that ICPs, epidemiologists, and other clinicians, stepped into the fray to provide calming confidence and accurate risk data.

"I'm beginning to think that we may be in a similar position now," he says. "We could have a very powerful educational and reassuring effect. Everybody's anxious about this, but I think we can diminish the level of anxiety," Schaffner adds.

Infection control methods in place

Health care workers must be educated about bioterrorism agents and provided reassurance that the patient isolation precautions developed by the Centers for Disease Control and Prevention (CDC) are extremely effective, urges Schaffner.[1]

"The barrier precautions are going to work for bioterrorism. Once you get to chemical [weapons] then you get into the whole 'moon suit' issue. But for bioterrorism, we don't need that," he says.

For example, systems of barrier precautions such as gloves, gowns, and masks to isolate patients infected with all manner of infectious diseases are already in place in virtually all U.S. hospitals.

"They work," he says. "Look, we all know pulmonary tuberculosis is communicable. I'm an infectious disease doctor, have been for 30 years. I've seen a lot of patients with tuberculosis, but I have also been meticulous about my use of [face masks and respirators]. My tuberculin test continues to be negative."

This supplement was prepared by Gary Evans, editor of *Hospital Infection Control.* Telephone: (706) 742-2515. E-mail: gary.evans@ahcpub.com.

A Bioterrorism Time Line

1155 Barbarossa uses the bodies of dead soldiers to poison the wells at the battle of Tortona.

1346 Mongols catapult corpses of plague victims into the city of Kaffa to infect the defenders.

1763 British commander Sir Jeffrey Amherst ordered the transfers of blankets used by British smallpox victims to Native American tribes, ostensibly as a gesture of goodwill, with the intention of inducing illness.

1970 The United States ends its programs of developing biological agents for use in warfare. The offensive use of such weapons was forbidden by U.S. policy under executive orders of President Richard Nixon.

1972 Soviet Union signs off on Biological and Toxin Weapons Convention, but continues a high-intensity program to develop and produce biological weapons at least through the early 1990s. Hundreds of tons of weaponized anthrax spores are stockpiled, along with dozens of tons of smallpox and plague. Many of these agents are reputed to have been specifically designed to be resistant to common antibiotics.

1984 Members of the Rajneesh cult contaminated salad bars in Oregon with salmonella, resulting in the infection of 751 people. The Paris Police raided a residence suspected of being a safe house for the German Red Army Faction. During the search, they found documentation and a bathtub filled with flasks containing *Clostridium Botulinum.*

1990s Japan's Aum Shinrykyo cult plans attacks using biological agents, specifically, anthrax and botulinum toxin. While these biological attacks were not successful, cult members later implemented the release of sarin nerve gas in the Tokyo subway system.

1995 A U.S. microbiologist with right-wing ties orders bubonic plague cultures by mail. The ease with which he obtained these cultures prompts new legislation to ensure that biologic materials are destined for legitimate medical and scientific purposes.

1998 A variety of feigned exposures to anthrax spores occurred in several U.S. cities including Indianapolis, where a full-scale response by emergency services and public health occurred before the episode was found to be a hoax.

Sources

1. Stewart C. *Topics in Emergency Medicine: Biological Warfare. Preparing for the Unthinkable Emergency.* Atlanta: American Health Consultants; 2000.

2. Bosker G. Bioterrorism: An update for clinicians, pharmacists, and emergency management planners. *Emergency Medicine Reports* (in press) 2001. ■

And anthrax, of course, is not communicable from person to person, reminds Schaffner, who investigated a case of occupational anthrax in an animal-hide worker when he was a epidemiologist for the CDC in the late 1960s.

"The bacteria do not cause a conventional pneumonia," he says. "They replicate locally and then release toxins. Because the bacteria never replicate to very high numbers the person is not communicable. It is not so much an infection as it is an intoxication."

Inordinate fear of anthrax could cause another problem — hoarding and misuse of Ciprofloxacin and other antibiotics. That tactic eventually could contribute to emerging resistance in pathogens such as *Streptococcus pneumoniae,* Schaffner notes.

"It is one thing for a hospital and the health department to develop an inventory in the event of an emergency," he says. "I do not recommend that individuals do that. I'm quite concerned that with antibiotics in their medicine cabinets there will be a temptation to just use it now and again for inadequate reasons in inadequate doses. If there was a recipe for antibiotic resistance — that's it."

More terror than toll

While the anthrax mailing campaign now under way sends out another shock wave with every news report, the tactic will likely result in more terror than actual toll. The rapid administration of antibiotics has offset illness following exposures, the disease is not communicable from those actually infected, and everyone is now on high alert for suspicious mailings.

Indeed, if the wave of anthrax mailings continues, postal-treatment technologies may become a growth industry.

Regardless, anthrax is problematic as a bioweapon because only a certain micron size of the inhaled spore will lodge in the upper lungs where it can release its toxins, says **Allan J. Morrison Jr.**, MD, MSc, FACP, a bioterrorism expert and health care epidemiologist for the Inova Health System in Washington, DC.

"If it is too large, it won't go in," says Morrison, a former member of the U.S. Army Special Forces. "If it's too small, it goes in and moves about freely without ever lodging. This is not as easy as getting a culture, growing it in your home, and the next day having infectious microbes.

"The sizing, preparation, and ability to deliver such a weapon are extremely difficult," he adds.

The Aum Shinrykyo cult in Tokyo attempted at least eight releases of anthrax or botulism during 1990 to 1995 without getting any casualties, he recalls. **(See time line, p. 2.)** Variables such as humidity can come into play, clumping up spores even if they are perfectly sized for inhalation. Anthrax spores bound for human targets are also at the whims of ultraviolet light, rain, and wind dispersal patterns, Morrison says.

"It is a very hostile climate for microbes on planet earth." Morrison says. "The intent may be widespread, but the ability to deliver weapons grade agents is going to be restricted to a very small subgroup. And even among them, they still will require optimal climatic conditions to carry it out. There will be causalities, as in war, but the distinction here is that there has not been widespread infection."

While anthrax is the current weapon of choice, the direst scenarios usually turn to the most feared weapon in the potential arsenal of bioterrorism: smallpox.

"Invariably, I have seen smallpox described as 'highly infectious,'" Schaffner says. "It's not. That is erroneous." For example, during the global eradication efforts in the 1960s, African natives infected with smallpox were often found living with extended families in huts, he adds. "It would usually take two to three incubation periods for smallpox to move through an extended family."

"It doesn't happen all it once. This was a critical concept in the strategy to eradicate smallpox. If you could find smallpox, you could vaccinate around that case and prevent further transmission. If it had been a frighteningly [rapid] communicable disease, that strategy would never have worked," Schaffner explains.

In addition, some medical observers question the certitude of the general consensus that all those vaccinated decades ago are again susceptible to smallpox. They argue that those immunized during the eradication campaign may at least have some greater protection against fatal infection.[2]

Regardless, rather than dropping like flies, as many as 70% of those infected with smallpox actually survive and then have lifelong immunity.

While there are many other agents to discuss and prevention plans to outline in the weeks and months ahead, perhaps the greatest protective factor is the unprecedented level of awareness in the health care system. The world has changed so much since Sept. 11th that hospitals are probably more prepared for bioterrorism than they have ever been. Everywhere, lines of communication have been opened with health departments and affiliated clinics, emergency plans have been reviewed and hot-button phone numbers posted on the wall.

"We're on alert," says **Fran Slater**, RN, MBA, CIC, CPHQ administrative director of performance improvement at Methodist Hospital in Houston. "We are *all* on alert."

References

1. Garner JS, the Centers for Disease Control and Prevention Hospital Infection Control Practices Advisory Committee. *Guideline for Isolation Precautions in Hospitals. Web site: http://www.cdc.gov/ncidod/hip/ISOLAT/isolat.htm.*
2. Bosker G. Bioterrorism: An update for clinicians, pharmacists, and emergency management planners. *Emergency Medicine Reports* (in press) 2001. ■

Should clinicians get smallpox vaccinations?

Questions arise, stockpile expansion fast-tracked

The recent decision to accelerate production of a new smallpox vaccine is raising the complex question of whether health care workers — front-line soldiers in the war against bioterrorism — should be immunized against the disease.

As opposed to the current anthrax attacks, a biological release of smallpox would result in incoming patients with an infectious disease. Even health care workers directly exposed to anthrax could be treated with ciprofloxacin and several other antibiotics, so the anthrax vaccine is not a likely candidate for health care.

On the other hand, legitimate questions have been raised about whether health care workers will stay on the job during a smallpox outbreak unless they and their families are rapidly vaccinated. The only known stocks of smallpox virus are held by the United States and Russia, but many bioterrorism experts have warned for years that another nation or group might have secret stocks.

"I think if smallpox [vaccine] became available, we should definitely immunize all the health care workers," says **Martin Evans**, MD, hospital epidemiologist at the University of Kentucky Chandler Medical Center in Lexington. "A lot of people think [health care workers] ought to

be high on the list because they are part of the response team if there was an outbreak in the community. Not to sound self-serving, but I think we ought to immunize the medical community."

But the question currently is somewhat moot because the Centers for Disease Control and Prevention (CDC) is not wavering from its established policy of mobilizing the available vaccine only if smallpox is released. "I'm sure CDC wants to conserve its current stocks for dealing with an outbreak so it could immunize contacts," Evans says. "If [the agency has] already used [its stock] by immunizing all the health care workers in the country, then it won't be able to respond."

15 million doses stockpiled

Currently, there are some 15 million doses of the old smallpox vaccine available, according to Secretary of Health and Human Services **Tommy Thompson,** who recently announced plans to accelerate production of a new smallpox vaccine. Forty million new doses of vaccine are expected to be available by mid-to-late 2002, moving the project up considerably from its original completion date of 2004 or 2005.

The manufacturer of the new vaccine is Acambis Inc. (formerly OraVax) — based in Cambridge, UK, and Cambridge and Canton, MA. The new vaccine will be a purified derivative of the same strain of cowpox virus (vaccinia) that was used in the United States previously, because the old vaccine's efficacy was clearly demonstrated by direct exposures to those infected. While the method of immunization through scarification will be essentially the same, the new vaccine will be produced in a mammalian cell culture that contains no animal protein.

Acambis stated on its web site that it would have no other comment on the project other than to confirm it has "accelerated" its production plans. But when the project was first announced in 2000, company officials said they had the ability to scale up production well beyond the requested 40 million doses. They were even scouting for other global markets. That means the capability to produce smallpox vaccine in abundance is on the horizon, and the question of immunizing health care workers will invariably arise. *Bioterrorism Watch* was unable to get a CDC response on the question as this issue went to press, but CDC director **Jeffrey Koplan**, MD, MPH, outlined the agency's position in an Oct. 2, 2001 Health Alert posted on a CDC web site.

"Smallpox vaccination is not recommended and, as you know, the vaccine is not available to health providers or the public," Koplan said. "In the absence of a confirmed case of smallpox anywhere in the world, there is no need to be vaccinated against smallpox. There also can be severe side effects to the smallpox vaccine, which is another reason we do not recommend vaccination. In the event of an outbreak, the CDC has clear guidelines to swiftly provide vaccine to people exposed to this disease. The vaccine is securely stored for use in the case of an outbreak."

One factor in favor of the CDC's position to rapidly deploy the vaccine — rather than do widespread vaccinations — is that immunization should still be effective several days after a smallpox exposure. In the smallpox global eradication campaign, epidemiologists found they could give vaccine two to three days after an exposure and still protect against the disease. Even at four and five days out, immunization might prevent death. Still, though the new vaccine will be improved in many ways, the hazards and risk factors of introducing cowpox into the human body are expected to be roughly the same as those documented with the old vaccine.

"We are looking at probably about one death per million primary vaccinations," says **D.A. Henderson**, MD, director of the Center for Civilian Biodefense Studies at Johns Hopkins University in Baltimore. "We are looking at one in 300,000 developing post-vaccinal encephalitis — an inflammation of the brain, which occasionally is fatal and sometimes can leave people permanently impaired."

Based on those estimates, if the new stockpile of 40 million doses is eventually rolled out, approximately 40 of those immunized will die, and another 133 will develop encephalitis. In addition to those severe outcomes, the arm lesion created during inoculation can be very large and painful, serving as a reservoir to self-inoculate the eyes or even infect immune-compromised patients.

The downside is real, but as more vaccine becomes available immunization will certainly be discussed at hospitals in previously targeted areas such as New York City and Washington, DC. If they are not immunized in advance, health care workers are going to want vaccine very quickly if they are expected to take care of smallpox patients, says **Allan J. Morrison Jr.**, MD, MSc, FACP, health care epidemiologist for the Inova Health System in Washington, DC. "Forget about smallpox patients. We're talking about taking care of any patients." ■

Patient Education Management™
For Nurse Managers, Education Directors, Case Managers, Discharge Planners

Continuing Education Test

JULY

1. To help diagnose hypertension, people should be taught to keep a record of their blood pressure and look at the average, not one reading, or look for a trend.
   A. True
   B. False

2. Which of the following steps should be followed to create a culturally appropriate video?
   A. Assemble culturally appropriate focus groups.
   B. Hire a bilingual scriptwriter.
   C. Interview colleagues.
   D. A & B

3. When patient education committees are put to good use they may accomplish which of the following?
   A. Create classes.
   B. Redesign documentation forms.
   C. Measure outcomes.
   D. All of the above

4. To help prevent skin cancer in adulthood, children should be taught to routinely apply sunscreen daily in all seasons.
   A. True
   B. False

AUGUST

5. According to the new cholesterol guidelines issued by the National Cholesterol Education Program, healthy adults age 20 and older should have a lipoprotein profile once every five years. This would include which of the following?
   A. Measuring total cholesterol.
   B. Measuring levels of LDL.
   C. Measuring levels of HDL.
   D. All of the above.

6. The advantages of on-line support groups include which of the following?
   A. There are no space restrictions.
   B. People don't have to leave home.
   C. Advice can be freely given.
   D. A & B

7. Group appointments work best for chronic disease patients, such as those with asthma, diabetes, congestive heart failure, or hypertension.
   A. True
   B. False

8. Curriculum for staff training on domestic violence should include which of the following components?
   A. Guidelines for assessment.
   B. Information on documentation and reporting.
   C. Details on intervention.
   D. All of the above

SEPTEMBER

9. The purpose of many glucose screenings offered as a community service by health care institutions is to:
   A. increase awareness.
   B. uncover people who are asymptomatic.
   C. diagnose diabetes.
   D. A and B

10. When teaching staff about good health communication, which of the following information should be included in the curriculum?
    A. Facts about the health literacy problem
    B. Tips on writing easy-to-read materials
    C. Examples of medical jargon patients don't understand
    D. All of the above

11. People who are considering joining the national registry for marrow donation, need to understand:
    A. there are two types of transplants.
    B. it's important that donors be committed.
    C. donors must be in good general health.
    D. All of the above

12. It's good to get input from parents when shaping patient education materials and programs because they have a unique perspective on the needs of family and children.
    A. True
    B. False

OCTOBER

13. Without a bone mineral density test, people do not know they have osteoporosis until they experience a bone fracture.
    A. True
    B. False

14. Pain management depends on several factors; therefore, an assessment should include:
    A. cultural beliefs.
    B. past experience with pain.
    C. coping styles.
    D. All of the above

15. The attributes of a user-friendly resource center include:
    A. topics in lay language.
    B. private rooms for video viewing.
    C. staff who approach visitors only if asked.
    D. A & B

16. When a child with a chronic illness prepares to go back to school, education should cover:
    A. how to answer peers' questions.
    B. coping strategies for pain.
    C. a child's worries or concerns.
    D. All of the above

NOVEMBER

17. Which of the following methods increase efficiency in patient education?
    A. On-line educational materials
    B. Standardized teaching and documentation
    C. Video on demand
    D. All of the above

18. To teach patients about pain management, many health care facilities are developing which of the following teaching materials?
    A. Teaching sheets on pain
    B. Bill of rights on pain management
    C. Web sites for self-learning
    D. A and B

19. Which of the following steps should be taken when using another institution's materials as a blueprint in order to avoid copyright law?
    A. Obtain written permission
    B. Avoid wording content the same way
    C. Include an attribution on material
    D. All of the above

20. When children have a sibling in the hospital, it's important that they gain an understanding what's going on, including the illness, so that they don't live in fear of it thinking that it might happen to them or that they did something wrong to cause it.
    A. True
    B. False

DECEMBER

21. Good time-management techniques used by patient education managers include which of the following?
    A. Computer software applications
    B. Delegation of tasks
    C. Prioritizing workload
    D. All of the above

22. Which of the following techniques are used to ensure that patient education is being documented?
    A. Chart audits
    B. Shadowing employees
    C. Docking pay
    D. Posting personal documentation errors

23. Screening for colorectal cancer could help prevent the disease by detecting polyps in their pre-cancerous form.
    A. True
    B. False

24. To effectively use nonpharmacological pain management techniques with children, it is important to do which of the following?
    A. Tailor technique to age
    B. When possible, work with child
    C. Select technique and stick to it
    D. A and B

Patient Education Management
Continuing Education Evaluation

Please take a moment to answer the following questions to let us know your thoughts on the continuing education program. Place an "x" in the appropriate space and return this page in the envelope with your test answer form. Thank you.

For your reference, here is the stated purpose of *PEM*:
To help nurse managers, education managers, case managers, and discharge planners increase their knowledge of patient education and perform their duties effectively and efficiently.

Did *Patient Education Management* enable you to meet the following objectives*:*

yes__ no__1. Are you able to identify clinical, legal, or educational issues related to patient education?

yes__ no__ 2. Are you able to explain how those issues impact health educators and patients?

yes__ no__ 3. Are you able to describe practical ways to solve problems that care providers commonly encounter in their daily activities?

yes__ no__ 4. Are you able to develop or adapt patient education programs based on existing programs from other facilities?

yes__ no__ 5. Did these objectives help accomplish the overall purpose of the program?

yes__ no__ 6. Were the teaching/learning resources effective for this activity?

7. How many minutes do you estimate it will take you to complete **this entire semester's** (6 issues) activities? Please include time for reading, reviewing, testing, and studying the answer sheet, which you will receive with your certificate. One nursing contact hour equals 50 minutes._____ minutes

yes__ no__ 8. Were the test questions clear and appropriate?

yes__ no__ 9. Were the instructions clear and appropriate?

yes__ no__ 10. Were you satisfied with the customer service for the CE Program?

11. Do you have any general comments about the effectiveness of this CE Program?

Patient Education Management™

For Nurse Managers, Education Directors, Case Managers, Discharge Planners

2001 Index

When looking for information on a specific topic, back issues of Patient Education Management *newsletter, published by American Health Consultants, may be useful. To obtain back issues, go on-line at www.contraceptiveupdate.com. Click on "archives." Nonsubscribers can purchase stories at www.ahcpub.com. Click on the section titled "On the web," and then "AHC Online." Or contact our customer service department at P.O. Box 740060, Atlanta, GA 30374. Telephone: (800) 688-2421 or (404) 262-7436. Fax: (800) 284-3291 or (404) 262-7837. E-mail: customerservice@ahcpub.com.*